* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 2156-99

268826

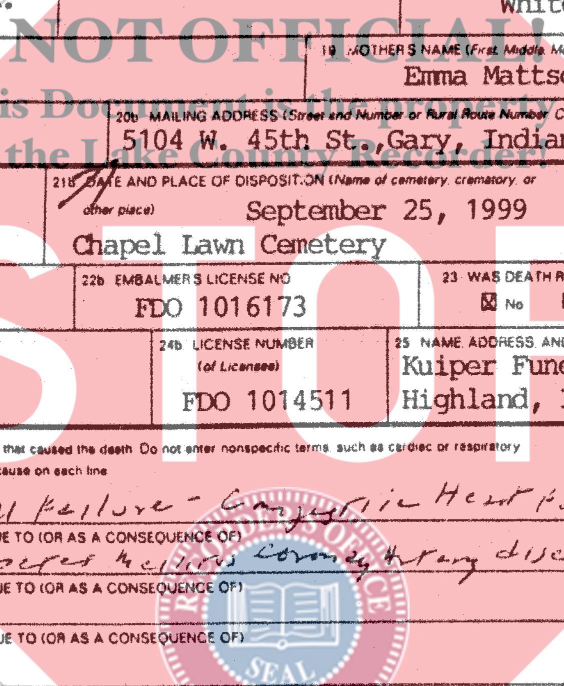
INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK



DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	NANCY SHINKLE
2. Sex	FEMALE
3a. Time of Death	1:50 P.M
3b. Date of Death (Month, Day, Yr)	SEPTEMBER 22, 1999
4. *Social Security Number	311-32-9193
5a. Age—Last Birthday (Years)	63
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo, Day, Yr)	Feb. 13, 1936
7. Birthplace (City and State or Foreign Country)	Superior, Wisconsin
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	THE COMMUNITY HOSPITAL
9c. City, Town, or Location of Death	MUNSTER
9d. County of Death	LAKE
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	Charles P. Shinkle
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Home Maker
12b. Kind of Business/Industry	Own Home
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town, or Location	Gary (Calumet Township)
13d. Street and Number	5104 W. 45th St.
13e. Zip Code	46408
13f. Inside City Limits	☒ No ☐ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	U.S.A.
15. Was Decedent of Hispanic Origin? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	Douglas Dunn
19. Mother's Name (First, Middle, Maiden Surname)	Emma Mattson

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Charles P. Shinkle
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	5104 W. 45th St., Gary, Indiana 46408
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	September 25, 1999 Chapel Lawn Cemetery
21c. Location—City or Town, State	Schererville, Indiana
22a. Embalmer's Name	Edgar C. Gleim
22b. Embalmer's License No.	FDO 1016173
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FDO 1014511
25. Name, Address, and License Number of Funeral Home	Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 83007500

CAUSE OF DEATH

26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Failure - Congestive Heart Fa[ilure]

DUE TO (OR AS A CONSEQUENCE OF) b. Alzheimer's Mellitus Coronary Artery disease

DUE TO (OR AS A CONSEQUENCE OF) c.

DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no) — no

28a. Was an Autopsy Performed? (Yes or no) — no

28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no) — no

CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

SEP 24 1999

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

29a. Certifier (Check only one)

- ☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
- ☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated
- ☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

Field	Entry
29b. Signature and Title of Certifier	[signature] MD
29c. Medical License No.	01026158
29d. Date Signed (Month, Day, Year)	SEPTEMBER 231999
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	ADELA PEREZ, M.D. 2156 HART STREET DYER, INDIANA 46311

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Alexander S. Williams MD
32. Date Filed (Month, Day, Year)	September 23, 1999

Field	Entry
33. Manner of Death	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. Date of Injury (Month, Day, Year)	
34b. Time of Injury	
34c. Injury at Work? (Yes or no)	
34d. Describe How Injury Occurred	
34e. Place of Injury—At home, farm, street, factory, office building, etc. (Specify)	
34f. Location (Street and Number or Rural Route Number, City or Town, State)	
34g. Date Pronounced Dead (Month, Day, Year)	
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

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FILED OCT 04 1999 PETER BENJAMIN LAKE COUNTY AUDITOR

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DS 9.00